

40131 JAN -6

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02194

1. DECEASED NAME (TYPE OR PRINT)		FIRST RAYMOND		MIDDLE HERBERT		LAST BAYER		2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR 23 ⁵⁵ M	
3. SEX M	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB 20 1908		6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 1 - 1 19 87		2d. HOUR 27 ⁵⁵ M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.					
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASST. SEC.		12b. KIND OF BUSINESS OR INDUSTRY NATL LUMBER			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN ELICOTT CITY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3401 N. SPRINGES DR. 21013			
14. FATHER'S NAME FIRST MIDDLE LAST JACOB BAYER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE BAYER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 146-83-7293		17. INFORMANT ADDRESS MARGARET WILLSON 11213 TRUDELPARK RD ELICOTT CITY MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas F. Herbert MD				TITLE (SPECIFY) Deaths M.D.				MEDICAL EXAMINER DATE SIGNED 1-2-87			
EXAMINER'S NAME (TYPE OR PRINT) Thomas F. Herbert MD				ADDRESS Ellicott City, MD 21043							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2 JAN 87		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM. PK.				23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE BALD. MD.			
24. FUNERAL DIRECTOR NAME ADDRESS SLACK FUNERAL HOME BOX 268				25a. DATE REC'D. BY REGISTRAR FEB 3 1987		25b. REGISTRAR'S SIGNATURE					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

REG. NO.

24 FUNERAL DIRECTOR NAME AMBROSE FUNERAL HOME		ADDRESS 1328 SULPHUR SPRING ROAD		25a. DATE REC'D. BY REGISTRAR FEB 3 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

BP.

DHMH - 16 60M 7/B4
(VRA 15, 4)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02196
REG. NO.

FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Steven		FIRST Cobis		LAST		2a. DATE OF DEATH MONTH DAY YEAR 1-18-87		2b. HOUR 1235 PM	
3. SEX male		4. RACE cauc.		5. DATE OF BIRTH MONTH DAY YEAR 2 25 03		6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co. MD.			
10. CITY OR TOWN OF DEATH Ellicott City, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Ex. Care Fac.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bread man		12b. KIND OF BUSINESS OR INDUSTRY Bakery	
13a. STATE Maryland		13b. COUNTY Balt. City		13c. CITY OR TOWN Balt. City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2527 W. Lombard St. Balt., MD. 21223	
14. FATHER'S NAME FIRST MIDDLE LAST Gabriel Cobis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Teresa Holicar		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (YES) W.W.I		16b. SOCIAL SECURITY NO. 216-07-8331		17. INFORMANT ADDRESS Leanora T. Cobis BSECF, Ellicott City, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Squamous cell carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) Dementia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9-10 1/17 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-10 1/17 1987 to 1/17 1987 , that (I) (we) last saw the deceased alive on 1/17 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L. Barahona		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. BARAHONA		22e. ADDRESS M. D. 9380 BALTIMORE NAT'L PIKE		Ellicott City, Md. 21043					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/21/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A.A. Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,				ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D BY REGISTRAR JAN 21 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

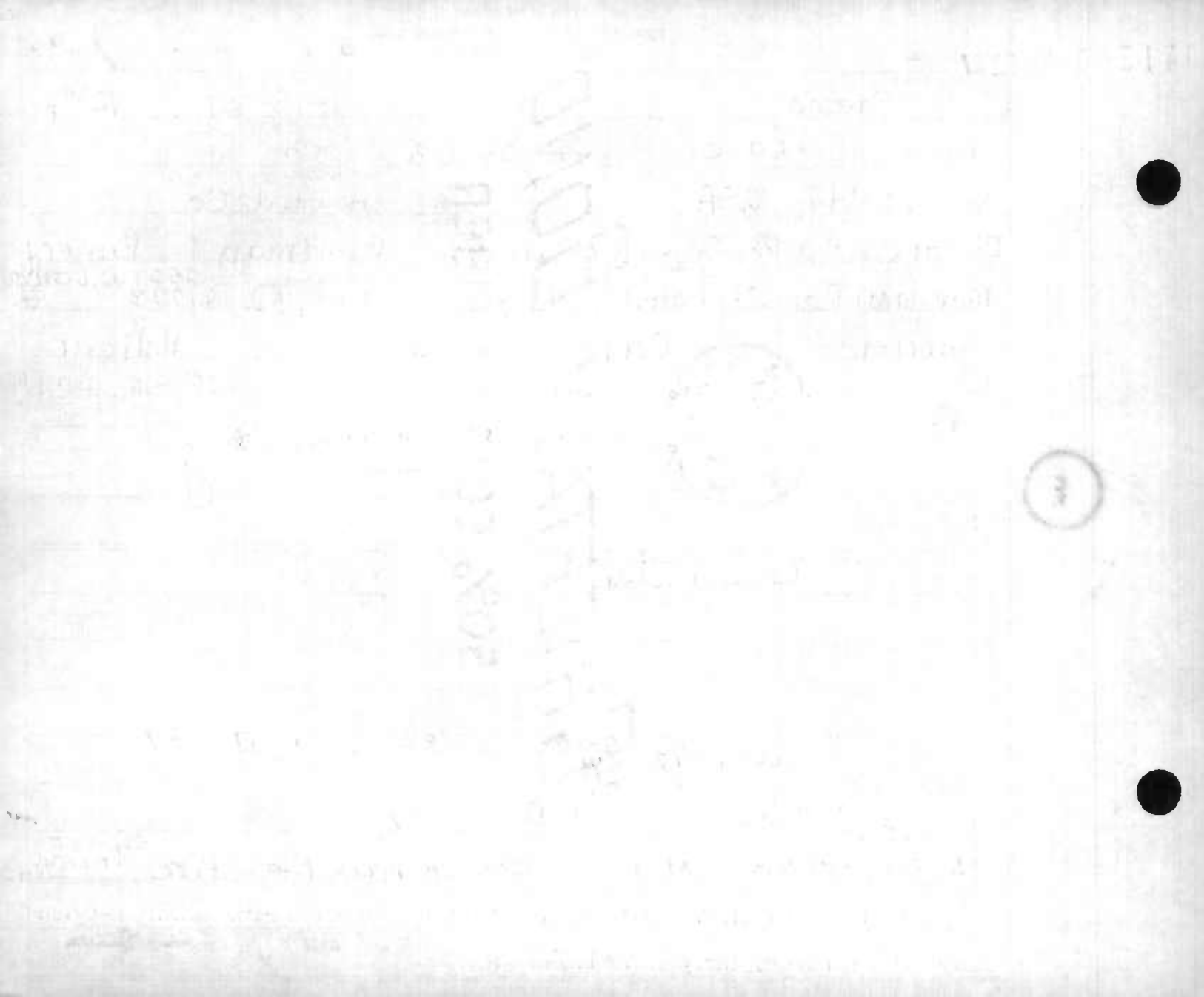
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a attending physician and completely filled in on the funeral director, page 3 should be detached for use on the burial transit permit. Then it should be given to the funeral director. Pages 4 and 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed and signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRS 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RALPH P. COLBY			2a. DATE OF DEATH MONTH DAY YEAR 1 9 87			2b. HOUR 7:45 P.M.	
3. SEX M		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR 5 14 00		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Bank Auditor	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick J Colby				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lulle Penniman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 024 01 3604		17. INFORMANT ADDRESS Fred Colby 4583 Darby Rd Dade City Florida 33525			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>CONGESTIVE HEART FAILURE</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5</u> , 19 <u>87</u> , to <u>1-9</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1-9</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>1-9-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert G. Brown, MD</u>		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE January 12'87		23c. NAME OF CEMETERY OR CREMATORY Westview Meorial Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Maryland	
24. FUNERAL DIRECTOR NAME Harry H Witzke & Family Funeral Home 4112 Old Columbia Pike Ellicott City				25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

Inc

041860

JAN 27 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02198

1. STATE REGISTRAR		7. REG. NO.	
2. DECEASED NAME (TYPE OR PRINT) Ophelia C. Collins		7a. DATE OF DEATH MONTH DAY YEAR 1 17 87	
3. SEX Female	4. RACE WHITE	7b. HOUR 10:50 PM	
5. DATE OF BIRTH MONTH DAY YEAR JAN 27 1911		8. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN.	
11. CITIZEN OF WHAT COUNTRY? USA		12. BALTIMORE CITY OR COUNTY OF DEATH Howard	
13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hosp.		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland. 15b. COUNTY Howard. 15c. CITY OR TOWN Columbia		16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 407-09-1993	
17. INFORMANT PETER MAROTTA - 8908 Potomac Station Rd Potomac		18. ADDRESS	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic obstructive pulmonary dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yrs.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
22a. I certify that (I) (this hospital) attended the deceased from 12 26 19 86 to 1/17 19 87, that (I) (we) last saw the deceased alive on 1/17 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Charles E. Sheehan MD	
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS	
24a. BURIAL, CREMATION, REMOVAL (SPECIFY) Rock Creek		24b. DATE JAN. 21. 1987	
24c. NAME OF CEMETERY OR CREMATORY Rock Creek.		24d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C. Rock Creek Ch. Rd. N. W.	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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White

House

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1937 May 12

Columbus

State

Columbus

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041841 JAN 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 02199

1. DECEASED NAME (TYPE OR PRINT) Robert William Daniels, Sr.			2a. DATE OF DEATH MONTH DAY YEAR January 23, 1987			2b. HOUR 2:05 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 14 1917		6. AGE (IN YEARS LAST BIRTHDAY) YRS 69		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County			
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8414 Horseshoe Dr., Ellicott City				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Oilburner Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Oil	
13a. STATE Md.		13b. COUNTY Howard		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 8414 Horseshoe Dr. 21043			
14. FATHER'S NAME FIRST MIDDLE LAST Leo Daniels				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Weinrich					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 215-07-9908		17. INFORMANT ADDRESS Catherine Daniels 8414 Horseshoe Dr. Ellicott City, 21043			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) coronary artery disease, Chronic angina DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) acute inferior myocardial infarction 1977									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 77 to Jan 19 87 , that (I) (we) last saw the deceased alive on Dec 18 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eugenio E. Benitez				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENIO E. BENITEZ				22e. ADDRESS 3455 Wilkins Ave Balto 21279					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/26/87		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md			
24. FUNERAL DIRECTOR NAME HARRY H. WITZKE & FAMILY FUNERAL HOME, INC. Ellicott City, Md. 21043				25a. DATE REC'D. BY REGISTRAR JAN 27 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

117

January 22, 1937

Mr. J. H. ...
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...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroborated pages 1 and 2 should be filed with 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 02200	
1. FOR STATE REGISTRAR Florence Decker					
1. DECEASED NAME (TYPE OR PRINT) Florence Decker		2a. DATE OF DEATH 1 MONTH 27 DAY 8 YEAR		2b. HOUR 7 25 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 22, 1898	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorian Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Howard		13c. CITY OR TOWN Elkridge		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
14. FATHER'S NAME FIRST MIDDLE LAST Nels Nelson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridget Tracy		13d. STREET ADDRESS / ZIP CODE 100 Saint Jean Way 21227	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 077-22-5856		17. INFORMANT ADDRESS Mrs. Audrey Hajek Elkridge, MD. 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Atherosclerotic Heart Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one hour
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 86, to January 27, 19 87, that (I) (we) lost saw the deceased alive on January 27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Janet Ciarowski		DEGREE MD		22c. DATE SIGNED 1-27-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janet Ciarowski		22e. ADDRESS 2 Knoll North Drive Columbia Md 21045			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/28/87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	
24. FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke Funeral Home		25a. DATE REC'D. BY REGISTRAR 29 JAN 1987		25b. REGISTRAR'S NAME	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Maryland					

040130 JAN - 68

FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02201
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN E DELLER			2a. DATE OF DEATH MONTH DAY YEAR 01 01 87		2b. HOUR 2:40 AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 02 17 30		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD Co. MD.	
10. CITY OR TOWN OF DEATH COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LORIE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TELLER	12b. KIND OF BUSINESS OR INDUSTRY BANKING	
13a. STATE MARYLAND	13b. CITY OR TOWN HOWARD	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 3347-D NORTH CHATHAM RD. 21043		
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD L. SEALING SR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA H. MOORE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-28-9684	17. INFORMANT ADDRESS 1647B A.E. MULLINIX WOODBINE, MD. 21797			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) sepsis DUE TO, OR AS A CONSEQUENCE OF: (b) diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF: (c) decubitus ulcers Approximate interval between onset and death: 4 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) diabetic nephropathy, diabetic peripheral vascular disease					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 5 Dec 1986 to 12/31 1986 that (2) we saw the deceased alive on 12/31 1986 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.					
22b. SIGNATURE Rhodolmule MD		DEGREE	22c. DATE SIGNED 1/1/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KOLODRUBETZ MD		22e. ADDRESS LORIE NURSING HOME			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 3 JAN 87	23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S LUTHERAN CEM	23d. LOCATION CITY OR TOWN COUNTY STATE PFEIFFERS CEM. HOWARD MD.		
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME	ADDRESS BOX 268 ELICOTT CITY MD 21075	25a. DATE REC'D. BY REGISTRAR JAN 5 1987	25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit expires 48 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

10101010

10101010



042066 JAN 25 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8702202
REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove existing papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) STEPHAN		FIRST STEPHAN		MIDDLE DUBROSKY		LAST DUBROSKY		2a. DATE OF DEATH MONTH DAY YEAR 1-25-87		2b. HOUR 4³⁰ A.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 7-29-14		6. AGE (IN YEARS LAST BIRTHDAY) 72		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Furniture			
13a. STATE N.J.		13b. COUNTY Union		13c. CITY OR TOWN Berkley Hgts.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 194 Timber Drive. 07922		13f. ZIP CODE 07922	
14. FATHER'S NAME FIRST MIDDLE LAST John Dubrosky				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Sydor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 460-109726		17. INFORMANT ADDRESS Margaret A. Dubrosky 194 Timber Dr. Berkley Hgts. N.J. 07922					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC GASTRIC CARCINOMA. DUE TO, OR AS A CONSEQUENCE OF (c) YEARS.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Nov 19 86 , to Jan 25 19 87 , that (I) (we) lost saw the deceased alive on Jan 24 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/25/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leroy E. Cervier, MD				22e. ADDRESS Columbia, Md. 21046							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-28-87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE East Hanover, N.J.			
24. FUNERAL DIRECTOR NAME ADDRESS Gary L. Kaufman Funeral Home 5695 Main St. Elkridge, Maryland 21227						25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

1

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02203
REG. NO.1. FOR
STATE
REGISTRAR2. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Ida Evelyn V. Evans

2a. DATE OF DEATH

MONTH

DAY

YEAR

1-23-87

2b. HOUR

7:30 P.M.

3. SEX

Female

4. RACE

Cauc.

5. DATE OF BIRTH

MONTH

DAY

YEAR

06-24-10

6. AGE (IN YEARS LAST BIRTHDAY)

76

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Howard

MD.

10. CITY OR TOWN OF DEATH

Columbia

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Howard County General

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Clerk

12b. KIND OF BUSINESS OR INDUSTRY

St. of Md.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Howard

13c. CITY OR TOWN

Ellicott City

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

21043

14. FATHER'S NAME

Issac

M.

Marsh

15. MOTHER'S MAIDEN NAME

Ida

MIDDLE

Jackson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

212097610

17. INFORMANT

Ellicott City, Md. 21043

Maurice Evans 8642 Towne & Country Blvd, Apt. D

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Upper gastrointestinal bleeding

DUE TO OR AS A CONSEQUENCE OF

(b) Septic ulcer

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

stroke and coronary disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

19 84

to 1/23

19 87

saw the deceased alive on 1/23 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

1/27/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

BARAHONA

22e. ADDRESS

1101 MAIDEN CHOICE La 21229

23a. BURIAL, CREMATION, REMOVAL (S)

Burial

23b. DATE

Jan. 27, 1987 Marvin Chapel

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Mt. Airy

Carroll

MD

24. FUNERAL DIRECTOR

HARRY H. WITZKE & FAMILY FUNERAL HOME, INC.
4112 Columbia Pike, Ellicott City, Md. 21043

25a. DATE REC'D. BY REGISTRAR

JAN 27 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1, 2, and 4 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, the medical examiner must be notified at once.

011010 10010

U.S.A.

Maryland

27. of Md.

Clark

11003

3042 Towne & Country Rd., Apt. 2

Wilkesboro City

Howard

Maryland

Jackson

101

101

101

Wilkesboro City, Md. 21003

3042 Towne & Country Rd., Apt. 2

Jan. 27, 1987 Maryland Chapter

Butler

Mc. Airy Carroll

ARMY & NAVY FUNERAL HOME, INC.
4112 Columbia Pike, Wilkesboro City, Md. 21003

040056 JAN 6 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02204
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie Ida Fay			2a. DATE OF DEATH MONTH DAY YEAR January 01 87		2b. HOUR 9:50 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 30, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co. MD.	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John J. Sigman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine St. Pierre			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA	17. INFORMANT (Daughter) ADDRESS Mrs. Nancy Hester 7952 Covington Ave. Glen Burnie, Md. 21061		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Coronary Artery Disease 2 years</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Simult.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes Mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> 19 <u>86</u> , to <u>01/01</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>01/01/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>B. H. Minchew, M.D.</u>				22c. DATE SIGNED <u>01/01/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B. H. Minchew</u>				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>Jan 1, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Security Process, Inc.</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Catonsville Balto. Md.</u>		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR <u>Singleten Funeral Home</u>		24b. DATE REC'D. BY REGISTRAR <u>6 1987</u>		24c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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041469 JAN 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02205
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Edwin Flohr		2a. DATE OF DEATH MONTH DAY YEAR 1-17-87		2b. HOUR 4:40 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-8-00		6. AGE (IN YEARS, LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet maker		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
13a. STATE MD		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wilhelm Flohr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmina Werner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 123-09-9184		17. INFORMANT ADDRESS Margarete Flohr Apt 318 Columbia, Md. 21045 7080 Cradlerock Way					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Acute renal failure, diabetes mellitus, peripheral vasc ds</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> 19 <u>87</u> to <u>1/17</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>1/17</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (true) (false) (did not view the body after death)							
22b. SIGNATURE <u>Patricia A. Toyle</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/17/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA A. TOYLE MD		22e. ADDRESS 10772 Hickory Ridge Rd Columbia MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/21/87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Md.	
24. FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke Funeral Home				25a. DATE REC'D. BY REGISTRAR JAN 20 1987		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

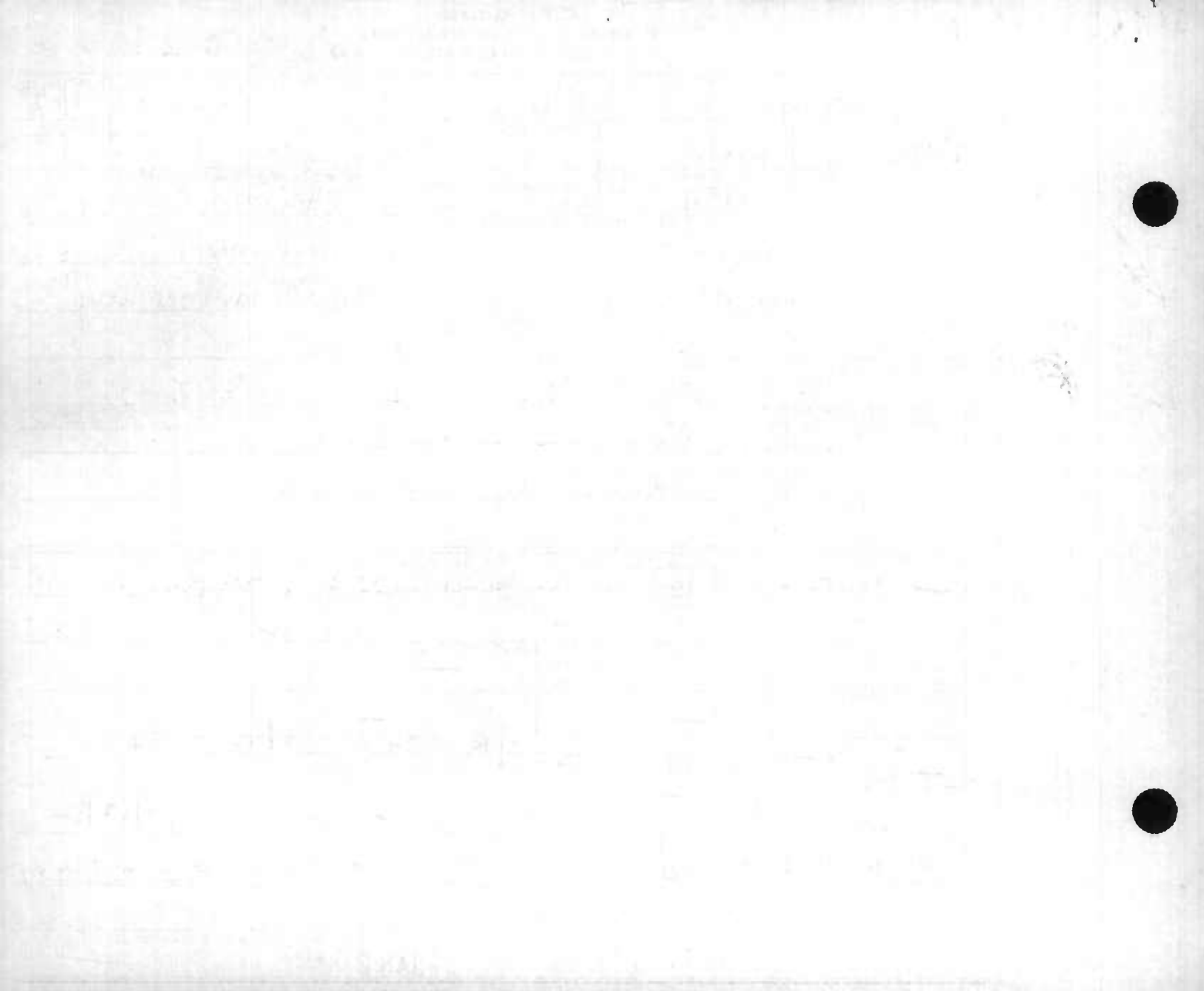
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpaper and should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the notified agency must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit permit. Their place on the death certificate papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 02200			
1. DECEASED NAME (TYPE OR PRINT) Irvin MELVIN GIBBS				2a. DATE OF DEATH MONTH DAY YEAR 1-24-87			
3. SEX male		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 8-15-11		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) accountant		12b. KIND OF BUSINESS OR INDUSTRY Nursing Home	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Claude M. Gibbs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma S.		16. SOCIAL SECURITY NO. 212-07-9187			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		17b. SOCIAL SECURITY NO. WWII		17. INFORMANT Ruth Gibbs ADDRESS 3945 Hawthorn Road Ellicott City, Md. 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic obstructive lung disease DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1973 , 19 87 , to January 24 , 19 87 , that (I) (we) last saw the deceased alive on January 24 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles E. Taylor		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-25-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles E. Taylor		22e. ADDRESS 2 Knoll North Drive, Columbia, Md 21045					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-28-87		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Maryland	
24. FUNERAL DIRECTOR HARRY M. H. WITZKE & FAMILY FUNERAL HOME, INC. 4112 Columbia Road Ellicott City, Md. 21043				25a. DATE REC'D. BY REGISTRAR JAN 27 1987		25b. REGISTRAR'S SIGNATURE Julia Dendron-Rundlett	

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2. *Journal of the American Medical Association*, 1997; 277: 1001-1005.

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Handwritten notes, mostly illegible due to fading. Some words like "The" and "and" are visible.

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DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 02208	
1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)				3. DATE OF DEATH				4. HOUR	
		Frances S Green				1 9 87				730A _M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		Black		05-15-10		76 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				HOWARD MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Columbia		Howard County General Hosp				Housewife					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS, ZIP CODE			
Md.		Howard		Jessup		YES <input type="checkbox"/> NO <input type="checkbox"/>		8787 Mission Rd/20794			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Daniel Thomas				Idella Allen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				212-20-2282		Elmer Green (son) 1421 Tiernan Dr. Glen Burnie, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardiac Dysrhythmia										30 min.	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Dis										years.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-9-87, 19, to 1-9, 19, 87, that (I) (we) lost saw the deceased alive on 1-8, 19, 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
Richard W. Smith M.D.								1-9-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Richard W. Smith						10802 Hickory Ridge Rd. Columbia Md. 21044					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				1-13-87		Asbury Cemetery		Jessup, Howard, MD			
24. FUNERAL DIRECTOR NAME				24b. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
George R. Snowden				246 N. Washington St. Rockville, MD 20850				JAN 16 1987 Julia Davidson-Randall			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02209
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANCES L. GROSSNICKLE			2a. DATE OF DEATH MONTH 1 DAY 21 YEAR 87			2b. HOUR 7 AM			
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH 4 DAY 22 YEAR 93		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD County MD.			
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nsg Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Howard 13c. CITY OR TOWN Ellicott City					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE 10114 Frederick Rd 21043		
14. FATHER'S NAME FIRST John MIDDLE T. LAST Garrick					15. MOTHER'S MAIDEN NAME FIRST Frances MIDDLE S. LAST McComas				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-09-4317		17. INFORMANT ADDRESS 812 Gorman Ave Apt. 330 20707 Name Irene Merica				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardio-pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) **Arteriosclerotic Cardio-vascular Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Cerebral vascular occlusion with right hemiparesis (1979)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-19 19 83 to 1-21 19 87 , that (I) (we) lost saw the deceased above 11-24 19 86 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas F. Herbert M.D.				DEGREE MD		22c. DATE SIGNED 1-22-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas F. Herbert, MD				22e. ADDRESS Ellicott City, MD 21043			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1-22-86		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. PK.		23d. LOCATION CITY OR TOWN Catonville COUNTY Balto. STATE MD.	
24. FUNERAL DIRECTOR NAME Slack Funeral Home ADDRESS Box 268 Ellicott City, Md 21043				25a. DATE REC'D. BY REGISTRAR JAN 28 1987 25b. REGISTRAR'S SIGNATURE John Anderson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, other traumatic event, the medical examiner must be notified.

The first of these is the
 fact that the system is
 not self-sufficient. It
 requires a constant supply
 of raw materials and
 energy. This is a major
 problem for the system
 as a whole. The second
 problem is the fact that
 the system is not
 flexible. It is unable to
 adapt to changing
 conditions. This is a
 major problem for the
 system as a whole.

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The third problem is the
 fact that the system is
 not secure. It is vulnerable
 to attack from within and
 without. This is a major
 problem for the system
 as a whole. The fourth
 problem is the fact that
 the system is not
 sustainable. It is unable to
 maintain itself over the
 long term. This is a major
 problem for the system
 as a whole.

042631 FEB-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 02210

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LAURA D. HARE			2a. DATE OF DEATH MONTH DAY YEAR 1/29/87		2b. HOUR 3:20 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec 4 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Genral Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker	12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE MD	13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2956 Marriottsville Rd. 21043	
14. FATHER'S NAME FIRST MIDDLE LAST Eugene E. Adams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hooper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 217-09-671		17. INFORMANT 11510 Frederick Road Charlotte Barnette Ellicott City, 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Congestive Heart Failure</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/27</u> 19 <u>87</u> to <u>1/29</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>1/28</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S.S. Minckew, M.D.				22c. DATE SIGNED 1-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-2-87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge	
23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City Howard MD		24. FUNERAL DIRECTOR HARRY H. WITZKE & FAMILY FUNERAL HOME 4112 Columbia Rd., Ellicott City, MD, 21043			
25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE Julia Benson-Badell	

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JAN 30 1987

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.
3. The third part is a description of the results
of the study.
4. The fourth part is a discussion of the results
and their implications.
5. The fifth part is a conclusion and a list of
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043155 FEB 5 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02211
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		2026M	
Thelma A. Hill		1-30-87			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	05-09-15	71 YRS.	MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore, Md.	U. S. A.		Howard Co. MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Columbia	5755 Cedar Lane Mcg Hosp.		Register Nurse- Hosp.		
13a. STATE	13b. COUNTY	13c. STREET ADDRESS / ZIP CODE	12b. KIND OF BUSINESS OR INDUSTRY		
MD.	Howard	21093 9014-Country Blvd.			
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
William G. Ahman	Thelma E. Rapper		NO. ----		
16b. SOCIAL SECURITY NO.		17. INFORMANT			
21243919		Son: Rocky Ridge, Md. 21778 Gregory A. Hill-13820 Motter Station Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21a. INJURY OCCURRED		21c. HOW INJURY OCCURRED		21b. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 30, 1987, to Jan 30, 1987, that (I) (we) lost saw the deceased alive on Jan 30, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Levan Kuck MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
LEVAN KUCK		Howard Co Gen Hosp Columbia MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2/2/87		Loudon Park Cemetery-Baltimore, Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Sterling Funeral Estate, P. A. 736 Edmondson Ave.; Catonsville, Md. 21228		FEB 3 1987		J. Hill	

041150

JAN 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 02212

1. DECEASED NAME (TYPE OR PRINT) Haverz			2a. DATE OF DEATH MONTH DAY YEAR January 3 1987			2b. HOUR 8:00 AM		
3. SEX F			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR 5 26 04		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard City General			9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY home			13a. STREET ADDRESS / ZIP CODE 3714 Valley Road 21043		
13b. STATE Md			13c. COUNTY Howard			13d. CITY OR TOWN Columbia		
14. FATHER'S NAME FIRST MIDDLE LAST John T Barnes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Elizabeth Johns			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		
16b. SOCIAL SECURITY NO. 213 74 1025			17. INFORMANT Lawrence House			17. ADDRESS 2912 Forsythe Avenue Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast metastatic to lung and bone DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Dec. 31, 1986, to Jan 3, 1987, that (I) (we) last saw the deceased alive on Jan 3, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Charles E Taylor			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-3-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles E Taylor			22e. ADDRESS 2 Knoll North Drive Columbia Md 21045					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE January 6, 1987			23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md			25a. DATE REC'D. BY REGISTRAR JAN 13 1987					
24. FUNERAL DIRECTOR NAME ADDRESS Donaldson Funeral Home, Laurel, Md								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, these remain carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 02213

1. DECEASED NAME (TYPE OR PRINT) JAMES E. HOUSTON			2a. DATE OF DEATH MONTH DAY YEAR 01 01 1987			2b. HOUR M			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 6 10 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8491 FREDERICK ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MIXER		12b. KIND OF BUSINESS OR INDUSTRY D.C.A. CORPORAT	
13a. STATE MARYLAND		13b. COUNTY Howard		13c. CITY OR TOWN ELLCOTT CITY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE 8491 FREDERICK ROAD, ELLCOTT CITY MARYLAND	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HOUSTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNE SNOWDEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-03-3853A		17. INFORMANT ADDRESS ELLCOTT CITY MARYLAND MARY J. HOUSTON 8491 FREDERICK ROAD 21043					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>squamous cell carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>left upper lung</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <u>11-17</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. Barahona</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leonel BARAHONA M.D.				22e. ADDRESS 9380 Balto Nat'l Pike City, MD 21043					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/6/1987		23c. NAME OF CEMETERY OR CREMATORY WESTERN STAR CEMETERY		23d. LOCATION CITY OR TOWN BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR NAME ADDRESS NU-TEC & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216				25a. DATE REC'D. BY REGISTRAR JAN 6 - 1987					
				25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued, it should be attached to the funeral-transit permit. The permit should be detached for use as the burial-transit permit. The permit should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, illness, traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02214
REG. NO.FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Emma</i> MIDDLE <i>W.</i> LAST <i>Jenkins</i>		2a. DATE OF DEATH MONTH <i>11</i> DAY <i>18</i> YEAR <i>87</i>		2b. HOUR <i>10A</i> M	
3. SEX <i>Female</i> F	4. RACE <i>White</i> W	5. DATE OF BIRTH MONTH <i>7</i> DAY <i>26</i> YEAR <i>1890</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>96</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Columbia</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ins. Agent</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>INA</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Md.</i> 13c. CITY OR TOWN <i>Balto.</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <i>Charles</i> MIDDLE <i>E.</i> LAST <i>Waggner</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Mollie</i> MIDDLE <i>Holt</i> LAST <i>Holt</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-14-5479</i>		17. INFORMANT ADDRESS <i>Rd. Frederick, Md. 21701</i> <i>Rev. Holt M. Jenkins, 8916 Yellow Springs</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Respiratory Distress</i>		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sepsis</i>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *None*

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>11:11</i> <i>11</i> <i>57</i> <i>1987</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>11/18</i> 19 <i>87</i> , to <i>11/18</i> 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>11/18</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Mark Dams MD</i>	DEGREE <i>MD</i>	22c. DATE SIGNED <i>11/18/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARK DAMS MD</i>	22e. ADDRESS <i>9057 BARTMATH PACE CC MD 21043</i>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>1/21/87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>
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24. FUNERAL DIRECTOR <i>J. E. Lowell Lemmon</i>	ADDRESS <i>10 W. Padonia Rd.</i>	25a. DATE REC'D. BY REGISTRAR <i>JAN 21 1987</i>	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendall</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach to the permit pages 1 and 2 and deliver to the funeral home. IMPORTANT: If item 21 is marked other than 18, the medical examiner must be notified.



041830 JAN 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02215
REG. NO.

1- DECEASED NAME (Type last, first, middle initial) Reuben Kahn		2a DATE OF DEATH MONTH DAY YEAR 1 18 87		2b HOUR 6:20 AM	
3 SEX Male	4 RACE W HITE	5 DATE OF BIRTH MONTH DAY YEAR 5 19 19		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.		10 CITY OR TOWN OF DEATH COLUMBIA		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD CO. GEN. HOSPITAL	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHARMACIST		12b KIND OF BUSINESS OR INDUSTRY DRUGS		13a STREET ADDRESS & ZIP CODE 4305 LABYRINTH RD. 21215	
13b CITY OR TOWN BALTO.		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST HYMAN KAHN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA UNKNOWN		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) YES	
16b SOCIAL SECURITY NO. 215-12-5892A		17 INFORMANT ARNOLD KAHN		17 ADDRESS 603 LEAFYDALE TERRACE #21208	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Circumstances of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Malignant pleural effusions R & L lung.					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 19 87	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (this hospital) attended the deceased from 1/17/87 to 1/18/87 , that (we) last saw the deceased alive on 1/17/87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.		22b SIGNATURE Warren M. Ross MD	
22c DEGREE MD		22d PHYSICIAN'S NAME (TYPE OR PRINT) WARREN M. ROSS, M.D.		22e ADDRESS HOWARD CO. GEN. HOSP. - COLUMBIA, MD	
23a BURIAL, CREMATION, REMOVAL (1) BURIAL		23b DATE JAN. 19, 1987		23c NAME OF CEMETERY OR CREMATORY WORKMEN CIRCLE	
23d LOCATION BALTIMORE		23e COUNTY MARYLAND		23f DATE REC'D. BY REGISTRAR JAN 28 1987	
24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.		24b ADDRESS 601 REISTERSTOWN RD. BALTO, MD 21215		25 REGISTRAR'S SIGNATURE Julia Robinson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10-12-40

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10-12-40

043798 FEB 11

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 0 2 2 1 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Heber (NMN) Kegley, Jr.			2a. DATE OF DEATH MONTH DAY YEAR Jan. 30, 1987		2b. HOUR 5 A. M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 17, 1932		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 54 8 13			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co. MD.			
10. CITY OR TOWN OF DEATH Woodbine		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 440 Woodbine Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Woodbine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 440 Woodbine Rd., 21797	
14. FATHER'S NAME FIRST MIDDLE LAST Heber Kegley, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alda Warden					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1950 to 1954		17. INFORMANT ADDRESS Evelyn M. Kegley, Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC GASTRIC CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ORGANIC HEART DISEASE S/P MITRAL VALVE REPLACEMENT									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Nario A. Eisenberger</i>		DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NARIO A. EISENBERGER				22e. ADDRESS 22 S. GREENE ST BALTIMORE MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-2-1987		23c. NAME OF CEMETERY OR CREMATORY Morgan Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Woodbine Carroll Md.			
24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR FEB 04 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon</i>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. These permits require completion of pages 1 and 2, which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 15 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. A. 100

Robert (M) Kiefer, Jr. Jan. 30, 1900 A.A.

White 17, 1922

U.S.A. Howard Co.

Woodbine and Woodbine

Woodbine Rd., NY

Robert, Jr. 1922

1922-23-24 Kiefer, Jr. 1922-23-24

Woodbine Rd., NY

HOLOCOX



Woodbine Rd., NY

Charles L. Kiefer, Jr., Knoxville, Tenn.

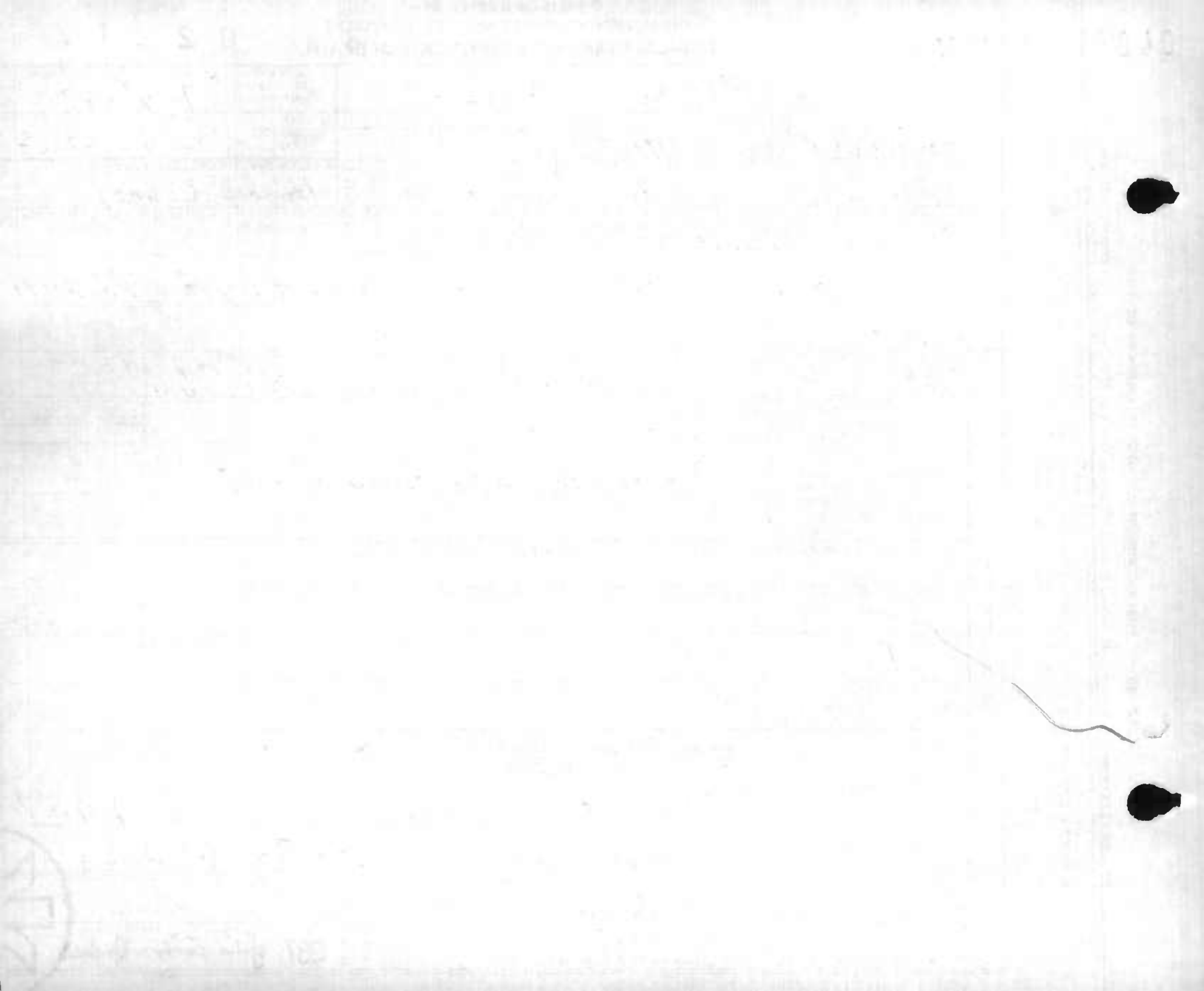
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02217	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Alice Martha KELLEY						DATE ESTIMATED		1-9	1987		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR
Female	Black	June 24 1897	89 YRS.			1-9 1987					8:00 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.				Howard County MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Columbia			5861 Harpers Farm Rd.								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Howard		Columbia		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5861 Harpers Farm Rd. 21044			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Robert Crouch				Mary							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				217-24-6567		URSULA GRUER		5861 Harpers Fm. Rd. Columbia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a): <u>Cardiac Failure</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <u>(b) Arteriosclerotic Cardio-vascular Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
				STREET		CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Thomas F Herbert				M.D. Deputy				1-9-87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Thomas F Herbert MD				Ellicott City MD 21043							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE			
Burial		14 Jan 87		Crestlaw Mem. Gdn.		Marriottsville		Howard MD.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS				Box 268		JAN 14 1987		Julia Sanders-Randall			
SLACK FUNERAL HOME				ELICOTT CITY, MD 21043							

MEDICAL CERTIFICATION



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

042342 JAN 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02218

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur N Kravetz			2a. DATE OF DEATH MONTH DAY YEAR 1 19 87			2b. HOUR 12 ² A.M.	
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 16 13		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHOTOGRAPHER		12b. KIND OF BUSINESS OR INDUSTRY PHOTOGRAPHY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 2504 WETHERBURN RD. #21209	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID KRAVETZ				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BLANCHE LICHTENSTEIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 220-07-9394		17. INFORMANT MRS. EILEEN COHEN 5130 PEPPE CT. COLUMBIA, MD 21045			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congenital heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>possible heart attack</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>2-3 days</u> <u>2-3 days</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <u>1-16</u> , 19 <u>87</u> , to <u>1-19</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12 MN</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Vincent Yang				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-19-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VINCENT YANG				22e. ADDRESS 8898 Blade Green Lane, Columbia, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 21, 1987		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD. BALTO., MD				25a. DATE REC'D BY REGISTRY JAN 28 1987		25b. REGISTRAR'S SIGNATURE	



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

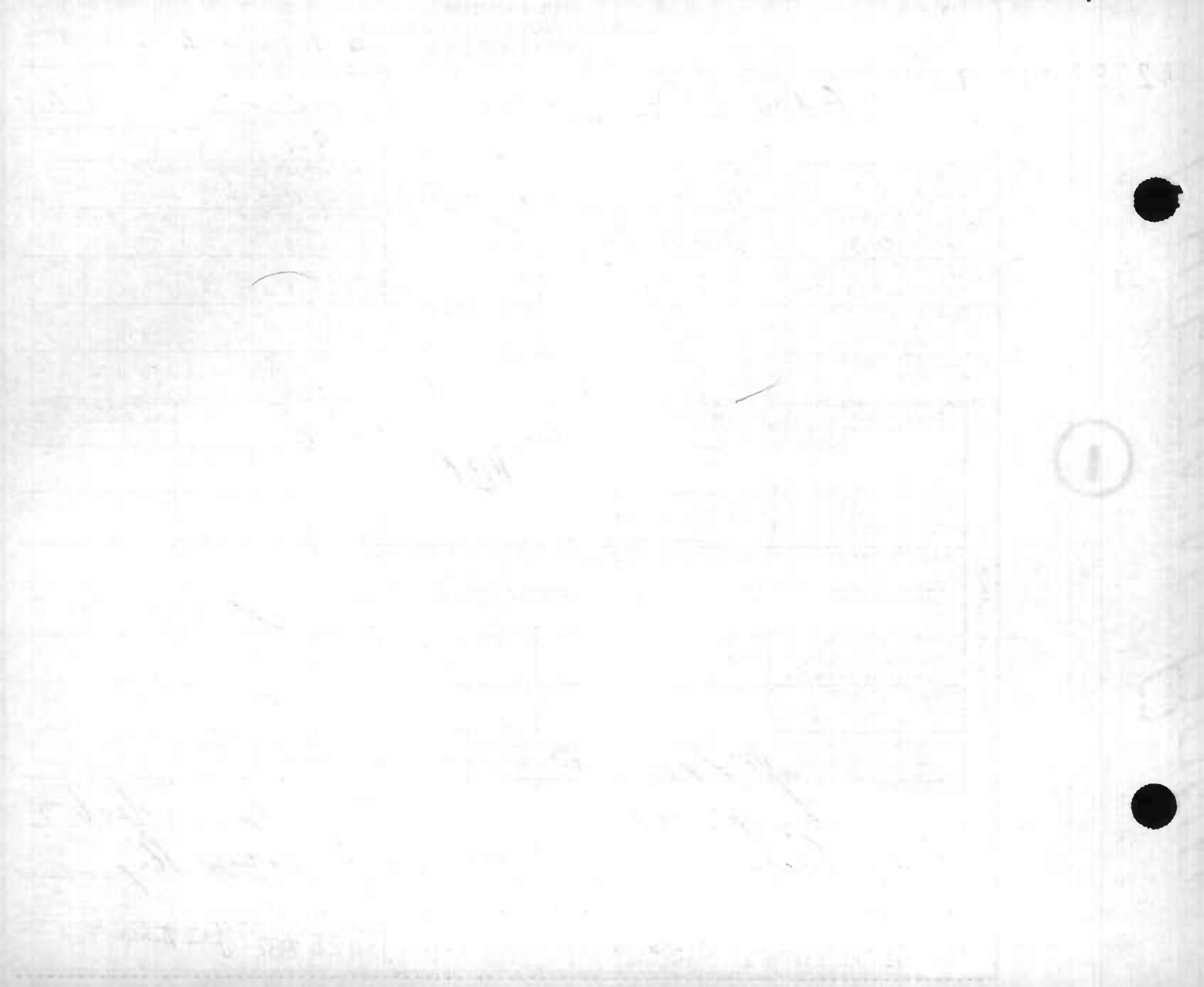
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8702219

1. DECEASED NAME (TYPE OR PRINT) FIRST EDNA MIDDLE M. LAST LAUB <i>Edna M. Laub</i>		2a. DATE OF DEATH MONTH DAY YEAR January 24, 1987		2b. HOUR 1:10 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 3 DAY 29 YEAR 03 <i>2 29 03</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LORION Nsg Home		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia	
14. FATHER'S NAME FIRST ABRAHAM MIDDLE LAST MAY		15. MOTHER'S MAIDEN NAME FIRST IDA MIDDLE LAST SCHWARTZ		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 091-03-6174		17. INFORMANT ADDRESS 6631 Queens Ferry Road Cleve Laub Jr. Baltimore, MD. 21239	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Conjunctive Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>HBP</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <i>1/24/87</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not perform the body after death.					
22b. SIGNATURE <i>Garrett</i>		DEGREE		22c. DATE SIGNED <i>1/24/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Garrett</i>		22e. ADDRESS <i>11055 Little Potomac Rd</i>		Columbia, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/26/87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Maryland		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <i>Julia Schenck-Randall</i>	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, MD. 21045					

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 02220

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Orastene Lawson		2a. DATE OF DEATH MONTH DAY YEAR 1 19 87		2b. HOUR 5:30 PM	
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 8- 10- 1947		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Marshall Texas	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard Md.	
10 CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public School
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Amster Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ora D. Durham			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 451-86-5619	17 INFORMANT ADDRESS Louis Williams 4631 Bernadine Drive San Antonio, Texas			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Carcinoma of the breast.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION N/A	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) N/A	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET		CITY OR TOWN	COUNTY STATE
22 I certify that (I) (this hospital) attended the deceased from <u>1/19/87</u> to <u>1/19/87</u> , that (I) (we) last saw the deceased alive on <u>1/19/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE William Flowers		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 1/19/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) William Flowers		22e ADDRESS 11055 Little Patuxent Columbia Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 1/31/87	23c NAME OF CEMETERY OR CREMATORY Adams Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Karnack Texas	
24 FUNERAL DIRECTOR NAME W. R. & Sons Funeral Home Inc.		ADDRESS 2501 Gwynn's Mills Pkwy. 21216		25a DATE REC'D. BY REGISTRAR JAN 23 1987	25b REGISTRAR'S SIGNATURE

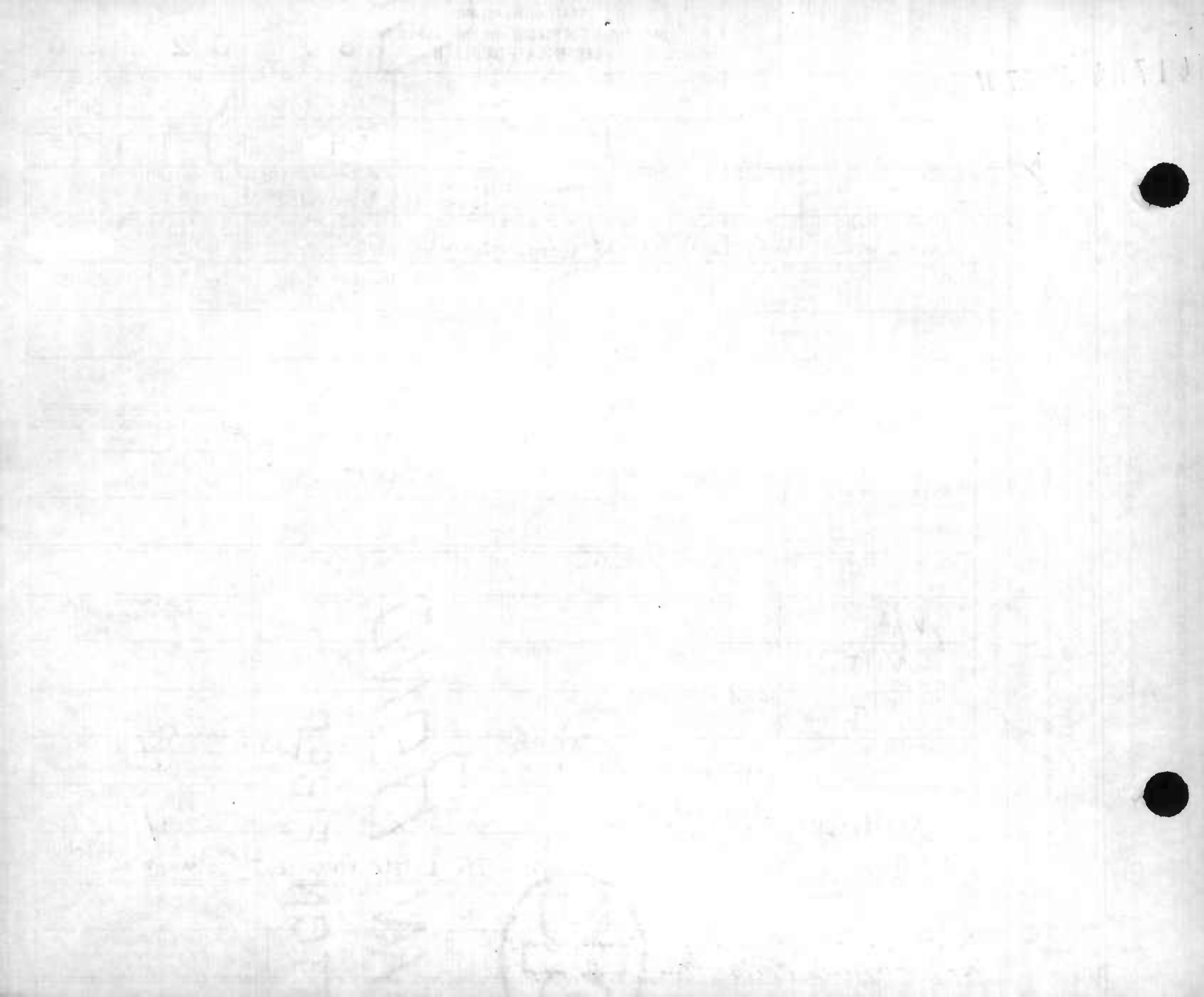
MEDICAL CERTIFICATION

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be called if one is available.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR P.M.
Carlton Palmer				MANN	1-8-87	11:04 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	White	3 15 1897		89 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
MASSACHUSETTS	USA			Howard County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Columbia	Howard County Gen Hosp			Retired		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. STREET ADDRESS / ZIP CODE		
13a. STATE Md.		13a. COUNTY Howard		13a. CITY OR TOWN Elkridge		13b. STREET ADDRESS / ZIP CODE 181 Keeton Rd. 21227
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
William B. Mann		Nancy C. Beal				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		
yes		WWI		15777 Haynes Road A. Helen Rogers Laurel, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram Negative Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sachemic Bowel</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Auto Renal Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Auto Renal Failure</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Archie J. Mann MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22c. DATE SIGNED 1/9/87		22d. ADDRESS 10772 Hickory Ridge Columbia				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION P.O. Md.
Burial		1/12/87		Resurrection Cem.		Clinton
24. FUNERAL DIRECTOR NAME		24. ADDRESS		25. DATE REC'D BY REGISTRAR		25. REGISTRAR'S SIGNATURE
7601 Sandy Spring Rd. Fleck Funeral Home, Inc., Laurel, Md.				JAN 16 1987		Julia Finken-Rudner

BP

REPORT

NOV 1951

UNITED STATES GOVERNMENT
OFFICE OF THE SECRETARY OF THE INTERIOR
BUREAU OF LAND MANAGEMENT



10-10-51

NOV 1951

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02222
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Greta K. McComish			2a. DATE OF DEATH MONTH DAY YEAR January 10, 1987			2b. HOUR 8:25 P.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 27, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66		7. IF UNDER 1 YEAR MONTHS DAYS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County, MD.			
10. CITY OR TOWN OF DEATH Ellicott City, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Extended Care-Cosmetician Beauty Parlor & Hairdresser				12b. KIND OF BUSINESS OR INDUSTRY 3045 Ramblewood Road-21043			
13a. STATE Md.				13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME FIRST MIDDLE LAST Karl Martin Krause				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amalia Leger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-36-7263		17. INFORMANT Mr. Luther Reese-901 Kent Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Disseminated Carcinoma of Cervix DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)									
22b. SIGNATURE Brad J. Cooper, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brad J. Cooper, M.D.						22e. ADDRESS 2850 Health Park Dr.-Ellicott City, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/12/87		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery-Ellicott City, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME ADDRESS Sterling Funeral Estate, P.A. 736 Edmondson Ave., Catonsville, Md. 21228.						25a. DATE REC'D. BY REGISTRAR JAN 13 1987		25b. REGISTRAR'S SIGNATURE Julia Deaton	

Approved 1/13/87
Sharon 2/2/87
Deputy M. H. 4/1/87
H. H. 4/1/87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Age 10-12 13-15 16-19 20-24

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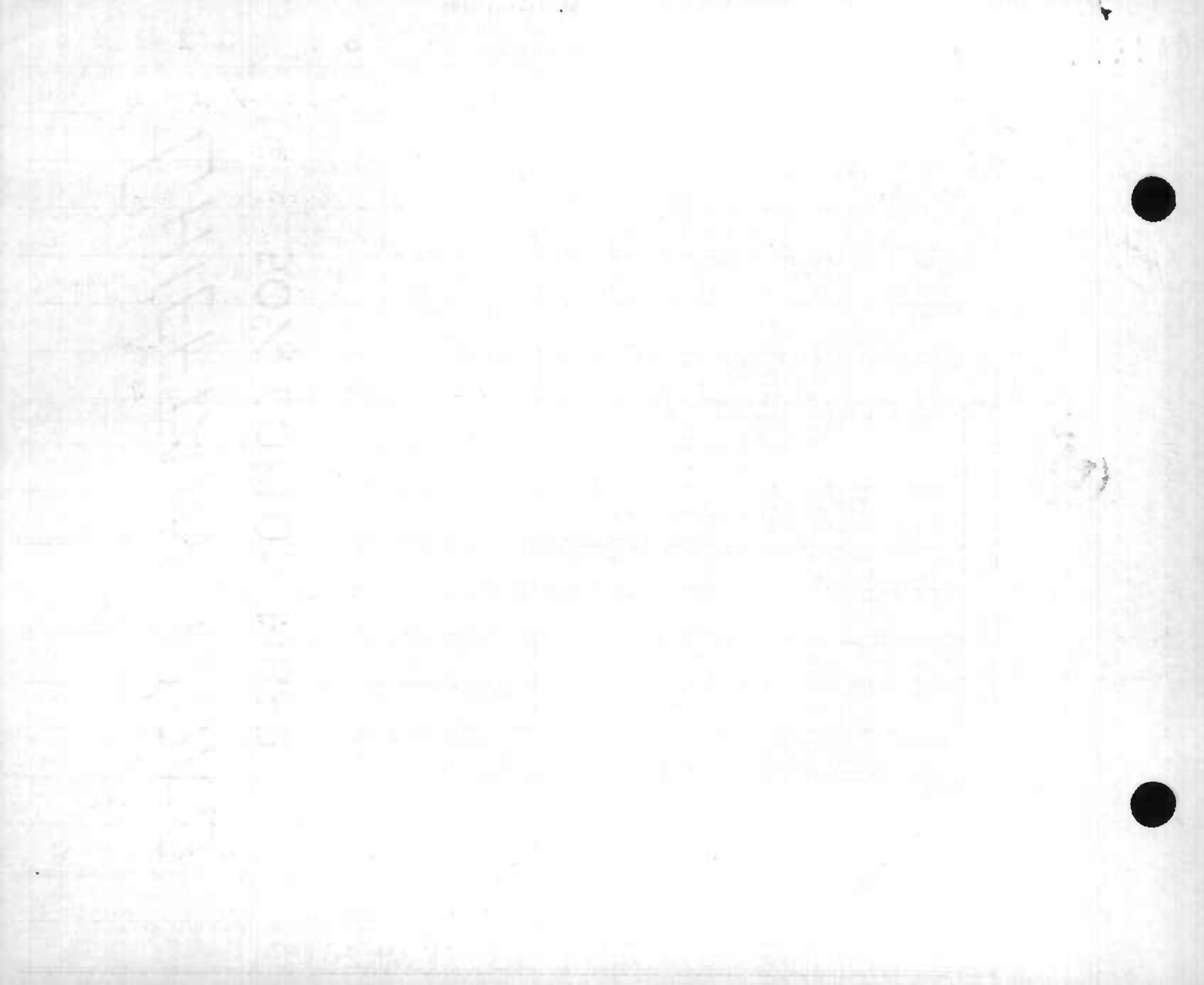
730 Madison Ave., Cottonville, Pa. 18041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROOSEVELT McKINLEY JR.					2a. DATE OF DEATH MONTH DAY YEAR January 16, 1987					2b. HOUR 1:10A M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 07 27 26		6. AGE (IN YEARS LAST BIRTHDAY) 60		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.							
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Gen. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Training Office			12b. KIND OF BUSINESS OR INDUSTRY Dept. of Trans.				
13a. STATE Maryland					13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5597 Vantage Point Road 21044	
14. FATHER'S NAME FIRST MIDDLE LAST Roosevelt McKinley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Brown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Maurine F. McKinley			ADDRESS Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Small Cell Cancer of Lung - metastatic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic anemia</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>85</u> , to <u>Jan 16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Jan 15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Jan K. M. Ford</u>					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-16-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jan K. M. Ford</u>					22e. ADDRESS <u>2400 North Columbia Md 21045</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/19/87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans			23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Maryland					
24. FUNERAL DIRECTOR <u>Leroy M. & Russell C. Witzke</u>					25a. DATE REC'D. BY REGISTRAR JAN 20 1987			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please notify the coroner's office. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST				MONTH DAY YEAR				MONTH DAY YEAR			
Regina E. Meissner				January 18, 1987				2:00 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS.	
Female		White		December 13, 1944		42		MONTHS DAYS		HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		U.S.A.				Howard County MD.					
12. CITY OR TOWN OF DEATH				13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Glenwood				14078 Stevens Valley Court 21738				Housewife			
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				16. INSIDE CITY LIMITS?				17. STREET ADDRESS			
15a. STATE 15b. COUNTY 15c. CITY OR TOWN				YES <input type="checkbox"/> NO <input type="checkbox"/>				14078 Stevens Valley Court			
Maryland Howard Glenwood											
18. FATHER'S NAME				19. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Horace W Bonekat				Jean Roche							
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				21. SOCIAL SECURITY NO.				22. INFORMANT ADDRESS			
No				202 34 2636				William C Meissner 14078 Stevens Valley Ct			
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>										<u>Immediate</u>	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										<u>18 mo</u>	
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>CNS metastases</u>											
(c) <u>Brain Cancer</u>										<u>5 1/2 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
24. DATE OF OPERATION				25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY?		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				29. TIME OF INJURY				30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
31. INJURY OCCURRED				32. PLACE OF INJURY				33. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				CITY OR TOWN COUNTY STATE			
34. I certify that (I) (this hospital) attended the deceased from <u>4/4</u> , 19 <u>87</u> , to <u>1/18</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/6</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.											
35. SIGNATURE				36. DEGREE				37. DATE SIGNED			
<u>Wm C Waterfield</u>				<u>MD</u>				<u>1/19/87</u>			
38. PHYSICIAN'S NAME (TYPE OR PRINT)				39. ADDRESS							
<u>Wm C Waterfield</u>				<u>St Agnes Hospital</u> <u>900 Caton Ave Balt Md 21229</u>							
40. BURIAL, CREMATION, REMOVAL (SPECIFY)				41. DATE				42. NAME OF CEMETERY OR CREMATORY			
Burial				Jan. 21, 1987				St Peter & Paul			
43. LOCATION				44. DATE REC'D BY REGISTRAR				45. REGISTRAR'S SIGNATURE			
Springfield Pennsylvania				JAN 21 1987							
46. FUNERAL DIRECTOR'S NAME ADDRESS											
Inc 4112 Old Columbia Pike Ellicott City											

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02225
REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARCELLA T. MURPHY			2a. DATE OF DEATH MONTH DAY YEAR 1 7 87			2b. HOUR A M			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7 16 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.			
10. CITY OR TOWN OF DEATH Glenelg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4061 Sharp Road 21737				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired.		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Richard Joseph Gartland			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Brennan			13e. STREET ADDRESS / ZIP CODE 6051 Foreland Gauth, Columbia 21045			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 093-24-4137		17. INFORMANT ADDRESS Joseph E. Murphy 4061 Sharp Rd. 21737					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Rheumatic Heart Disease with mitral regurgitation over 50 years**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

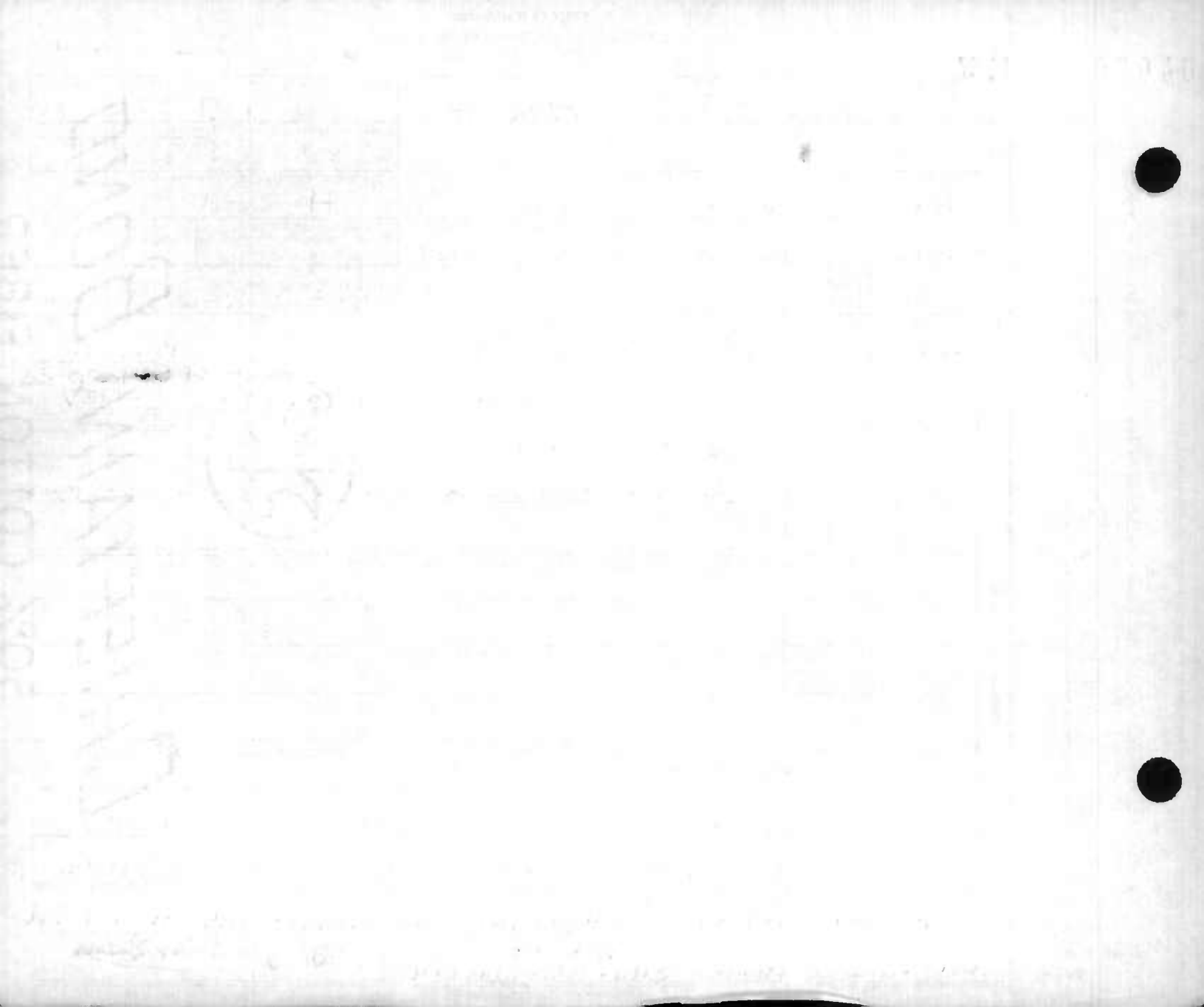
MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 3-12 , 19 85 , to January 7 , 19 87 , that (1) (we) last saw the deceased alive on December 30 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Janet S. Ciarkowski				DEGREE MD		22c. DATE SIGNED 1-7-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janet S. Ciarkowski MD.				22e. ADDRESS 2 Knoll North Drive Columbia Md 21045			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-9-87		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Mem. Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Howard Md.	
24. FUNERAL DIRECTOR NAME Shack Funeral Home				ADDRESS Box 268 Ellicott City, Md 21045		25a. DATE REC'D. BY REGISTRAR (b) REGISTRAR'S SIGNATURE JAN 14 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, death, traumatic event, the medical examiner must be notified at once.



041153 JAN 20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXHIBITED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND											
DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
REG. NO. 02220											
1. DECEASED NAME (TYPE OR PRINT) FIRST Peter MIDDLE P. LAST Onofrey			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1-11 1987		2b. HOUR M						
3. SEX Male	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 9-20-98	6. AGE (IN YEARS) LAST BIRTHDAY 98 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-11 1987	2d. HOUR M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD					
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10549 Gorman Rd				12. USUAL OCCUPATION (TYPE OF WORK) fire equipment inspector		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10549 Gorman Rd 20707			
14. FATHER'S NAME FIRST MIDDLE LAST unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 179 10 4697		17. INFORMANT ADDRESS Robert Alt same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Card-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Artero-sclerotic Card-p Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas F. Herbert			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER DATE SIGNED 1-11-87					
EXAMINER'S NAME (TYPE OR PRINT) Thomas F. Herbert, MD			ADDRESS Elkport City, MD 21043								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Bensalem, Penn				
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md				25a. DATE REC'D. BY REGISTRAR JAN 14 1987		25b. REGISTRAR'S SIGNATURE					

3

W

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2000

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 02221

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) <i>HELEN J. PARKER</i>		MONTH DAY YEAR <i>1 23 87</i>		2b. HOUR <i>3A</i> M	
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 8 94</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>92</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard</i> MD.	
10. CITY OR TOWN OF DEATH <i>Columbia</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County General</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>
13a. STATE <i>Md.</i>		13b. COUNTY <i>Howard</i>	13c. CITY OR TOWN <i>Fulton</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William A. Mitchell</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Martha Truelove</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>	
16b. SOCIAL SECURITY NO. <i>579-38-9885</i>		17. INFORMANT ADDRESS <i>Mrs. Freeman Hill same as 13e</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebrovascular accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):					
19a. DATE OF OPERATION <i>N/A</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER NOT MEDICAL EXAMINER) <i>N/A</i>			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> <i>N/A</i>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1/23</i> , 19 <i>87</i> , to <i>1/23</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>1/23</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>William Flowers</i>		DEGREE		22c. DATE SIGNED <i>1/23/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William Flowers</i>		22e. ADDRESS <i>11055 Little Retreat Pkwy Columbia Md.</i>			
23a. BURIAL, CREMATION, REMOVAL <i>Cremation</i>		23b. DATE <i>1/25/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Balto. Wash. Crematory</i>	
23d. LOCATION CITY OR TOWN <i>Laurel</i>		POLY. STATE <i>Md.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>7601 Sandy Spring Rd. Fleck Funeral Home, Inc. Laurel, Md. 20707</i>	
25a. DATE REC'D. BY REGISTRAR <i>JAN 27 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

Howard

Howard County, Maryland



40129 JAN -67

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02228

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE MARGARET LAST PICKETT			2a. DATE OF DEATH MONTH DAY YEAR JAN. 2 1987			2b. HOUR M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 19 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.	
10. CITY OR TOWN OF DEATH ELLCOTT CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HORSESHOE RD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY GEN. MCHDS.	
13a. STATE MD		13b. COUNTY HOWARD		13c. CITY OR TOWN ELLCOTT CITY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST JAMES MIDDLE J LAST MOAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE 5165 ILCHESTER RD. 21043			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-12-7631		17. INFORMANT ADDRESS 5165 ILCHESTER RD, ELLCOTT CITY, MD. 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE STROKE DUE TO, OR AS A CONSEQUENCE OF (b) CEROBROVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) DEGENERATIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONGESTIVE HEART FAILURE; DIABETES - TYPE II							
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A			
22. I certify that (I) (this hospital) attended the deceased from MAY 4 19 84, to JAN 2 19 87, that (I) (we) lost saw the deceased alive on SEPT 19 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Randy L. Reese, M.D.		DEGREE MD		22c. DATE SIGNED 1/2/87		22b. PHYSICIAN'S NAME (TYPE OR PRINT) RANDY L. REESE, M.D.	
22d. ADDRESS 2850 N. RIDGE RD ELLCOTT CITY, MD 21043		22e. ADDRESS 2850 N. RIDGE RD ELLCOTT CITY, MD 21043					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5 JAN 87		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS BOX 268 ELLCOTT CITY MD		25a. DATE REC'D. BY REGISTRAR JAN 5 1987		25b. REGISTRAR'S SIGNATURE Julia Seaton-Parker	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a funeral home physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove all nonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 21a, any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

42632 FEB-27

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies of pages 1 and 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the hospital examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 02229	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Michael J Pitt						2a. DATE OF DEATH MONTH DAY YEAR 1/28/87		2b. HOUR 3:45 PM			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 5 7 42		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH How and County MD					
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) systems analyst		12b. KIND OF BUSINESS OR INDUSTRY business			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Howard 13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10107 CARILLON CT 21033							
14. FATHER'S NAME FIRST MIDDLE LAST Merlin J. Pitt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myree Michael							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 219 40 9993		17. INFORMANT Janet Pitt		ADDRESS 10107 Carillon Court Ellicott City, Md., 21083					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC, PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) metastatic malignant melanoma DUE TO, OR AS A CONSEQUENCE OF (c) metastatic malignant melanoma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NA											
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/13/87 to 1/28/87 , that (I) (we) last saw the deceased alive on 1/28/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thomas J Koch				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/28/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas J Koch				22e. ADDRESS Howard County Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 2, 1987		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto Md.					
24. FUNERAL DIRECTOR HARRY H. WITZKE & FAMILY FUNERAL HOME, INC. 4112 Columbia Road, Ellicott City, Md., 2104											

JAN 30 1987

042387 JAN 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 02230

1. DECEASED NAME (TYPE OR PRINT) EFFIE Mildred POOLE			2a. DATE OF DEATH MONTH DAY YEAR 1/24/87			2b. HOUR 1:00 AM				
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 12 94		6. AGE (IN YEARS (LAST BIRTHDAY)) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.				
10. CITY OR TOWN OF DEATH COLUMBIA, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland					13b. COUNTY Howard		13c. CITY OR TOWN Woodbine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joshua C. Poole					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Mae Duvall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-02-6353		17. INFORMANT ADDRESS Raymond J. Becraft, Jr. Item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES DAYS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) NONE										
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —					
22. I certify that (I) (this hospital) attended the deceased from Jan 11, 1987 to Jan 24, 1987 , that (I) (we) lost saw the deceased alive on January 23, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22a. SIGNATURE Eric S. Tannenbaum			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/24/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERIC S. TANNENBAUM			22e. ADDRESS MEDICAL ARTS BLDG; 11055 WHITE PINE RD COLUMBIA, MARYLAND 21044							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 29, 1987		23c. NAME OF CEMETERY OR CREMATORY Jennings Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Florence, Howard, Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A., Damascus, Md.					25a. DATE REC'D. BY REGISTRAR JAN 29 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Budner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

3

040657 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02231

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE OF DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MONTH DAY YEAR	
Buford Lee Proudfoot								1 9 1987	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Male	White	11-09-43		43 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.		WIDOWED		DIVORCED		Howard County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Elkridge		384 Deep Run Parkway				Salesmanager		Auto	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Howard		Elkridge		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		384 Deep Run Parkway 21227	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Charles Buford Proudfoot				Virginia Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
YES		WWII		212-42-1247		Cathy L. Knight Westminster, MD 21157			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Gunshot wound of chest									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		? xx 1 9 1987		selfinflicted					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
		home		384 Deep Run Parkway, Elkridge, Howard, MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)						DATE SIGNED	
		Deputy Chief						1/10/87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
Ann M. Dixon, M.D.		111 Penn St.						Balto, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
CREMATION		01-12-87		Carroll Cremation Serv.		Hampstead		Carroll MD	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS									
HAIGHT FUNERAL HOME SYKESVILLE, MD 21784				JAN 13 1987		Julia Bender			

20% COTTON FIBER

ONE

100% COTTON

1. DECEASED NAME (TYPE OR PRINT)		FIRST Brenda		MIDDLE G.		LAST RICH		2a. DATE KNOWN OF DEATH		ESTI-MATED		MONTH 1		DAY 13		YEAR 1987		HOUR 530		MIN M			
3. SEX Female		4. RACE Cauc		5. DATE OF BIRTH MONTH 02 DAY 10 YEAR 45		6. AGE (IN YRS.) 45		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH 1		DAY 13		YEAR 1987		HOUR 530		MIN M	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.											
10. CITY OR TOWN OF DEATH Columbia				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home							
13a. STATE Maryland																							
13b. COUNTY Howard				13c. CITY OR TOWN Columbia				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 9455 Brett La. 21045											
14. FATHER'S NAME FIRST Aaron											MIDDLE LAST Zhger												
15. MOTHER'S MAIDEN NAME FIRST Francis											MIDDLE LAST Unknown												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 215-42-1976				17. INFORMANT ADDRESS Brian E. Rich - Same as Sec. 13															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adult respiratory distress syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Multi-drug overdose																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Days Weeks					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION											19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH											21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK											21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE Thomas F Herbert											TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 1-14-87				
EXAMINER'S NAME (TYPE OR PRINT) Thomas F Herbert MD											ADDRESS Ellicott City MD 21043												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 1/15/87				23c. NAME OF CEMETERY OR CREMATORY Westview Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. MD.											
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witke Funeral Home P.A. 5555 Twin Knolls Rd., Columbia, MD. 21045											25a. DATE REC'D. BY REGISTRAR JAN 16 1987				25b. REGISTRAR'S SIGNATURE Julia Bender-Rodden								

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only minor or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ROY

JAMES

RICHARDSON

2a. DATE OF DEATH

MONTH

DAY

YEAR

JANUARY 19, 1987

2b. HOUR

1:35 P.M.

3. SEX

MALE

4. RACE

WHITE

5. DATE OF BIRTH

JULY 25, 1912

6. AGE (IN YEARS LAST BIRTHDAY)

74

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

VA

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

HOWARD COUNTY

MD.

10. CITY OR TOWN OF DEATH

ELLCOTT CITY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

3104-A WHEATON WAY

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

ANGLESMITH

12b. KIND OF BUSINESS OR INDUSTRY

BETH. STEEL

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

HOWARD

13c. CITY OR TOWN

ELLCOTT CITY

13d. INSIDE CITY LIMITS?

YES ☐NO ☒

13e. STREET ADDRESS / ZIP CODE

3104-A WHEATON WAY 21043

14. FATHER'S NAME

GRAYSON

MIDDLE

RICHARDSON

15. MOTHER'S MAIDEN NAME

ELLA

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES; NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

216-07-5385

17. INFORMANT

ADDRESS

MS, ETHEL RICHARDSON 3104-A WHEATON WAY ELLCOTT CITY, MD 21043

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio-pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Cardio-vascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐NO ☒20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 7-24, 19 81, to 1-19, 19 87, that (I) (we) last saw the deceased alive on 9-27, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

Thomas F. Herbert, M.D.

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

1-20-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

THOMAS F. HERBERT, M.D.

22e. ADDRESS

3779 CHURCH ROAD, ELLCOTT CITY, MD 21043

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

22 JAN 87

23c. NAME OF CEMETERY OR CREMATORY

GOOD SHEPHERD CEM.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

ELLCOTT CITY HOWARD MD.

24. FUNERAL DIRECTOR

NAME

ADDRESS

SLACK FUNERAL HOME ELLCOTT CITY, MD 21043

25a. DATE REC'D. BY REGISTRAR

JAN 28 1987

25b. REGISTRAR'S SIGNATURE

John Davidson-Rodgers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 87 02234									
1. DECEASED NAME (Print or Print)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Myrtle Scaggs								January 6, 1987		11:00 a.m.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HOURS MIN.	
Female		White		10 8 11		75 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
		USA				Howard MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Scaggsville		8430 Old Columbia Road				housewife		home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md		Howard		Scaggsville				6430 Old Columbia Rd 20707			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
James W. Connell				Elsie Murphy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				218 80 5994		Melvin Scaggs same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of breast</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-26</u> , 19 <u>79</u> , to <u>1-6</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1-6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) <u>M.H. Chaudhry</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED <u>1/6/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M.H. Chaudhry, M.D.</u>										22e. ADDRESS <u>14201 Laurel Pk. Dr. #100 Laurel, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Jan 9, 1987		Emmanuel Cemetery		Scaggsville, Maryland					
24. FUNERAL DIRECTOR NAME <u>Donaldson Funeral Home, Md</u>						25a. DATE REC'D. BY REGISTRAR <u>JAN 09 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Penderson</u>			

NO 21 - 1 10 10

4

RECEIVED
10/10/10

215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is properly filed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 02235

1. DECEASED NAME (TYPE OR PRINT)		FIRST LILLIAN		MIDDLE	LAST SHINDLER	2a. DATE OF DEATH MONTH DAY YEAR JAN. 16, 1987				2b. HOUR 9:30 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MO OCT. 5, 1915 ^{AR}		6. AGE (IN YEARS LAST BIRTHDAY) 71		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN) MASS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.					
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) 5134 BEAVERBROOK RD. (21044)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PURCHASING AGENT		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.			
13a. STATE MASS		13b. COUNTY NORFOLK		13c. CITY OR TOWN BROOKLINE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 305 MASON TERR. (02146)			
14. FATHER'S NAME FIRST MIDDLE LAST SIMON BRASSLOW				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TDA UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 025-09-7317		17. INFORMANT ADDRESS ABRAHAM SHINDLER 305 MASON TERR. BROOKLINE MASS. 02146							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>pancreatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1</u> , 19 <u>86</u> , to <u>Jan 16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Jan 9</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Patience A. Toye, MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/17/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATIENCE A. TOYE, MD				22e. ADDRESS 10772 Hickory Ridge Rd Columbia, MD							
23a. BURIAL, CREMATION, REMOVAL BURIAL / REMOVAL		23b. DATE 1/19/87		23c. NAME OF CEMETERY OR CREMATORY KEHILLATH ISRAEL CEM		23d. LOCATION CITY OR TOWN COUNTY STATE RANDOLPH, MASS.					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)						25a. DATE RECEIVED BY REGISTRAR JAN 28 1987					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 2 2 3 0

1. DECEASED NAME (TYPE OR PRINT) Phillip E. Smith		2a. DATE OF DEATH REG. NO. 1-24-87 3:15 A.M.	
3. SEX Male Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 08 : 18 : 1908	6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hurlock, MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co. MD
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hos		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Warehouseman
13a. STREET ADDRESS / ZIP CODE Maryland AA Glen Burnie 21061		13b. KIND OF BUSINESS OR INDUSTRY A & P	
14. FATHER'S NAME FIRST MIDDLE LAST James Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Beckwith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 201-10-0279	
17. INFORMANT Mrs. Mary B. Smith, Same as 13		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Ventricular fibrillation, Decubitus ulcer, Dementia			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/20/87 to 1/24/87, that (I) (we) last saw the deceased alive on 1/24/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE [Signature]		22c. DATE SIGNED 1/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. DESAI		22e. ADDRESS 7001 Pine Crest Rd Balt 21229	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 27, 87	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA MD	
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR JAN 28 1987	
25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the resident/facile be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be deposited for use as the burial-transit permit. Then please remove certificates, pages 1 and 2 should be filed within 72 hours after death has been reported to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP_____

2000 COLUMN E12LB



100-400000-10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02237
REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Margaret (NMN) STEINER			2a DATE OF DEATH MONTH DAY YEAR Jan. 17, 1987			2b HOUR M AM				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 26, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard MD.				
10 CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Washington					13b COUNTY Grant		13c CITY OR TOWN Soap Lake		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Phillip Hood					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie (Unknown)					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT (Son) Mr. Norman J. Johnson		ADDRESS 502 Bathurst Road Catonsville, Md. 21228				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 6/12/86 to 12/24/86 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Ro					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert S. Goodwin					22e ADDRESS 9650 Santiago Road, Columbia, Maryland					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE January 20, 1987		23c NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland			
24 FUNERAL DIRECTOR NAME Glen Burnie, Maryland					25a DATE REC'D. BY REGISTRAR JAN 20 1987					
25b REGISTRAR'S SIGNATURE										

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove category 1 and 2 should be filed with the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ORIGINAL

APR 11 1963

Foreign Bureau Home

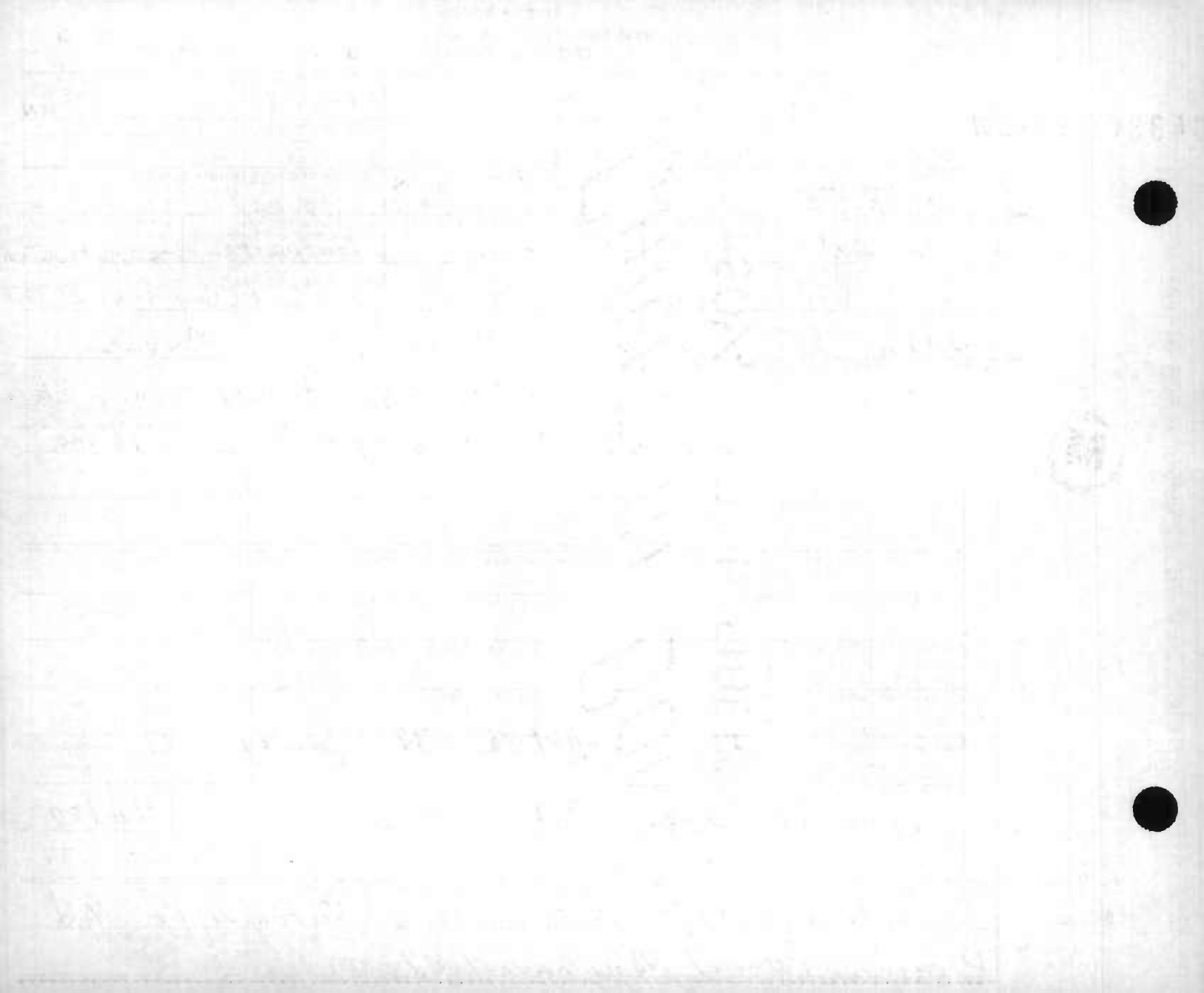
APR 17 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. STATE REGISTRAR		REG. NO. 87 02238									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Albert		L.		Taylor				1-29-87		12 ⁰⁰ MN	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS. HOURS MIN.	
Male		White		3-5-13		73 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. Married <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
U.S.A. VA		U.S.A.				Howard MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Columbia		Lorien Nsg. Home						Carpenter		construction	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md.		USA		Laurel				242 Red Clay Rd. 20707			
14a. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16. ADDRESS			
John L. Taylor				Margaret Myers				Dorothy Howell - same as above			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT			
No				228-100-833A							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple cerebral infarcts DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 mo.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/8/78 to 1978, that (I) (we) last saw the deceased alive on 1/23/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert S. McCeney M.D.						DEGREE M.D.		22c. DATE SIGNED 1/30/87		22d. ADDRESS 402 Main Street, Laurel, Maryland 20707	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Robert S. McCeney, M.D.				22f. ADDRESS 402 Main Street, Laurel, Maryland 20707							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 1/31/87		23c. NAME OF CEMETERY OR CREMATORY Westview Mem.		23d. LOCATION Catonsville Md			
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home Laurel Md				25a. DATE REC'D. BY REGISTRAR 1/30/87		25b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 02237

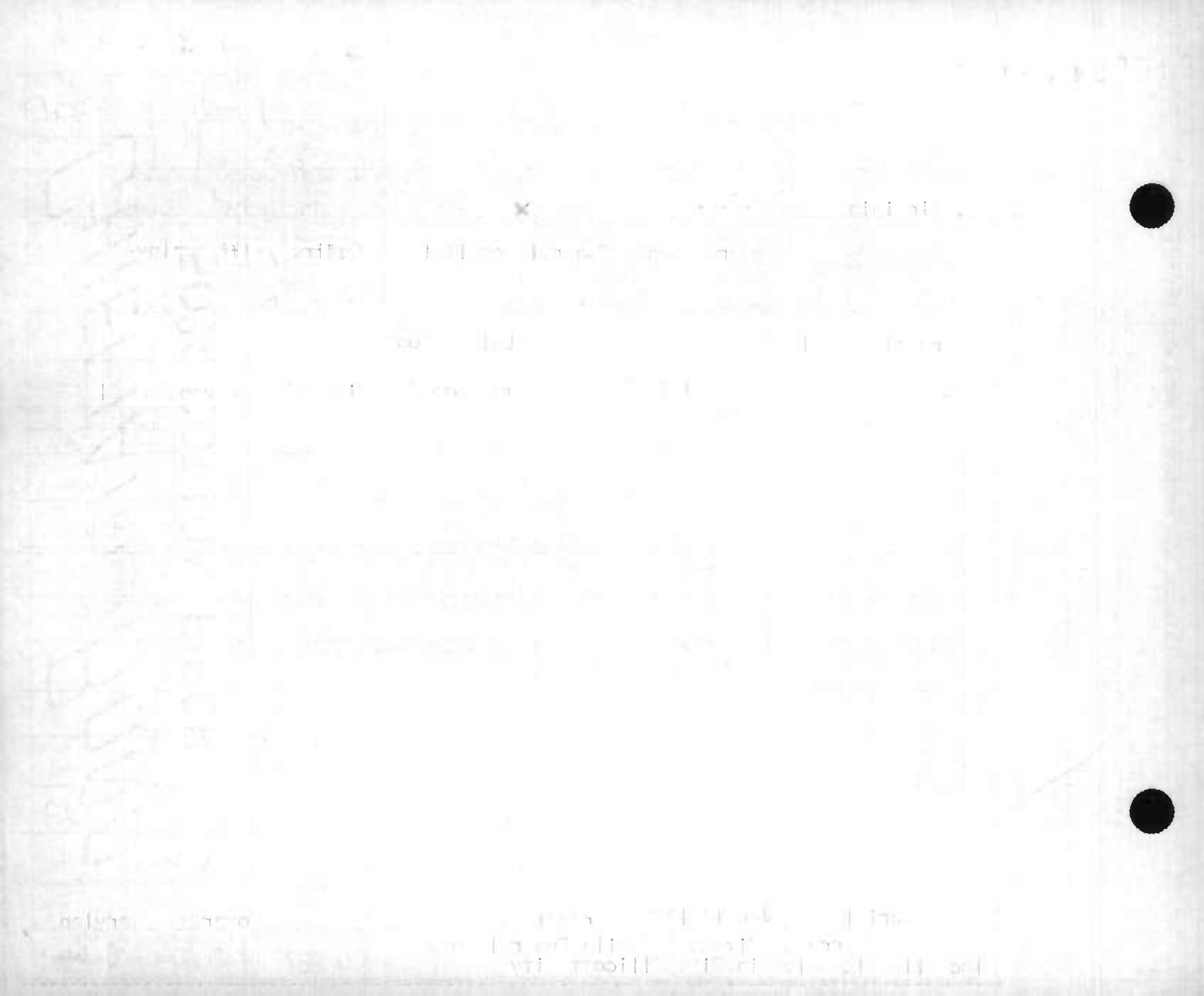
FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ralph J UPDIKE		2a. DATE OF DEATH MONTH DAY YEAR 1-11-87		2b. HOUR 201A	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 8 6	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest H Updike		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Cook		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Self. employed	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 137 07 8986		17. INFORMANT ADDRESS Mrs Ruth A Updike 3425 Dogwood Rd 21043	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (c) myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 2-3 hours 2-4 hours
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE (1400m) (201m)	
22a. I certify that (I) (this hospital) attended the deceased from Jan 11 1987 to Jan 11 1987 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE W.F. Andrew Lee		22c. DATE SIGNED 1/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.F. Andrew Lee		22e. ADDRESS Howard County General Hospital	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Crestlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Howard Maryland	
24. FUNERAL DIRECTOR NAME Harry H Witzke & Family Funeral Home				25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE Julia Tison-Rubner	



040227 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove confidential pages. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY O. WALKER					2a. DATE OF DEATH MONTH DAY YEAR 01 04 87					2b. HOUR 2125 PM
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 07 15		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 71 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.				
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Hutzler's		
13a. STATE MD.		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7080 Chadle Rock Way / 21045		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas T. Sinclair				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude C. Oliver						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-32-8781		17. INFORMANT ADDRESS Jane L. Waller 21222 7603 South Bend Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1/4 19 87, to 1/4 19 87, that (I) (we) lost saw the deceased alive on 1/4 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/4/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lloyd Stahl				22e. ADDRESS Howard County General Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-8-87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland				
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR JAN 6 1987		25b. REGISTRAR'S SIGNATURE Julia Duvon-Randall				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02241
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		12 ⁴⁰ PM	
Blanche L. Wallace		1-25-87			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
F	Cauc	MONTH DAY YEAR	92	MONTHS DAYS HOURS MIN.	
		12 20, 94			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH			
MASS.	HOWARD	COLUMBIA			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
LORIE N. NSG. HOME	Hecht Co.		Sales Clerk		
13a. STATE	13b. COUNTY	13c. STREET ADDRESS / ZIP CODE	13d. INSIDE CITY LIMITS?		
MD.	HOWARD	6612 Haviland Mill Rd.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
John B. Freneau	Louise Brodeur	N/A			
16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:			
578-103629	Dorothy Mowry (Niece)	Same as 13E			
IMMEDIATE CAUSE (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Cardiopulmonary Arrest					Sudden
DUE TO, OR AS A CONSEQUENCE OF					
(b) Atherosclerosis					Years
DUE TO, OR AS A CONSEQUENCE OF					
(c) Cerebrovascular Accident					Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital founded the deceased from Nov. 3, 1981, to Jan. 25, 1987, that (I) (we) last saw the deceased alive on Jan. 25, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	22c. DATE SIGNED			
Jerry I. Horne, MD	ATTENDING PHYSICIAN	4/27/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	22f. REGISTRAR'S SIGNATURE			
Jerry I. Horne, MD	Columbia, MD 21044				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	1/30/87	Ft. Lincoln	Brentwood PG Md.		
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hines/Rinaldi	11800 New Hamp Ave. Silver Spring, Md.		JAN 28 1987		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this permit, page 1, and 2 to the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other terminal event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 02242			
1. DECEASED NAME (TYPE OR PRINT) Elwood Simpson Wallich				2a. DATE OF DEATH MONTH DAY YEAR 01/06/87 09 11 04 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-11-1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6336 Cedar Lane; Apt. 336		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retail Sales		12b. KIND OF BUSINESS OR INDUSTRY Taylor Frn.	
13a. STATE Md. 13b. COUNTY Howard 13c. CITY OR TOWN Columbia				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6336 Cedar Lane, Apt 336, 21044	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Wallich				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellie May Harding			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-03-0757		17. INFORMANT ADDRESS Elwood L. Wallich 2921 Pinewick Rd. 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral artery disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/10 , 19 82 , to 1/6 , 19 87 , that (I) (we) lost saw the deceased alive on 12/16 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen A. Valenti MD DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen A. Valenti MD				22f. ADDRESS 11085 Little patuxent pky, Columbia, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-9-87		23c. NAME OF CEMETERY OR CREMATORY St. Marks Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Highland Howard Md.	
24. FUNERAL DIRECTOR NAME Slack Funeral Home ADDRESS Box 268 Ellicott City, Md. 21043				25a. DATE REC'D. BY REGISTRAR 14 1987		25b. REGISTRAR'S SIGNATURE Julia Sorenson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove card 1, pages 1 and 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) GARRY LYNN WEAVER									
2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1 20 87		1		20		87		11 ⁰⁰ P.M.	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR	
MALE		CAUCASIAN		MONTH DAY YEAR 11 2 35		51 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Ohio		USA				Howard County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Columbia		Howard County General Hospital				Howard County Elect. Eng.		JAN-APR	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.		Howard		Laurel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7917 Hammond Parkway 20707	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Dr. Carl H. Weaver					Vera A. Anderson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
no					283-32-5741		Lorna Weaver same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHOGENIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS MONTHS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 12.22.86 , 19____, to 1.20.87 , 19____, that (I) (we) last saw the deceased alive on 1.20.87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. DEGREE MD				22c. DATE SIGNED 1.21.87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T.A. DADISMAN JR MD				22e. ADDRESS 22001 NORTH DR. COLUMBIA MD 21045.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
cremation		1/21/87		Balt. Wash. Crematory		Laurel P.G. Md.			
24. FUNERAL DIRECTOR NAME Fleck General Home				25a. DATE REC'D. BY REGISTRAR ADDRESS 2601 Sandy Spg Rd Laurel, MD 20707		25b. DATE REC'D. BY REGISTRAR JAN 29 1987			

(1)

040779 JAN 16 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

02244

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Wilbur Williams</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>January 4, 1987</i>		2b. HOUR <i>12:45am</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 16, 1904</i>		
6. AGE (IN YEARS (LAST BIRTHDAY)) <i>82</i> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard</i> MD				
10. CITY OR TOWN OF DEATH <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lorien Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>engineer</i>		
12b. KIND OF BUSINESS OR INDUSTRY <i>U S Navy Yard</i>						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md</i>		13b. CITY OR TOWN <i>Howard</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13d. STREET ADDRESS / ZIP CODE <i>8845 Baltimore Street 20763</i>						
14. FATHER'S NAME FIRST MIDDLE LAST <i>Leonard Williams</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Clara Phelps</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>214 30 0479</i>		17. INFORMANT ADDRESS <i>Wilbur M. Williams 8855 Balt. St. Savage, Md</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio-respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Enlarged Prostate with indwelling Foley's catheter</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 1986</i> to <i>Jan 1987</i> , that (I) (we) lost saw the deceased alive on <i>12/30/1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.						
22b. SIGNATURE <i>Abdul Nazeem</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>1/5/87.</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ABDUL NAZEEM, M.D.</i>		22e. ADDRESS <i>3456-FORT MEADE Road, LAUREL, M.D. 20707</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>January 7, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Savage Cemetery</i>		
23d. LOCATION (CITY OR TOWN) COUNTY STATE <i>Savage, Maryland</i>						
24. FUNERAL DIRECTOR <i>Donaldson Funeral Home, Laurel, Md</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 09 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

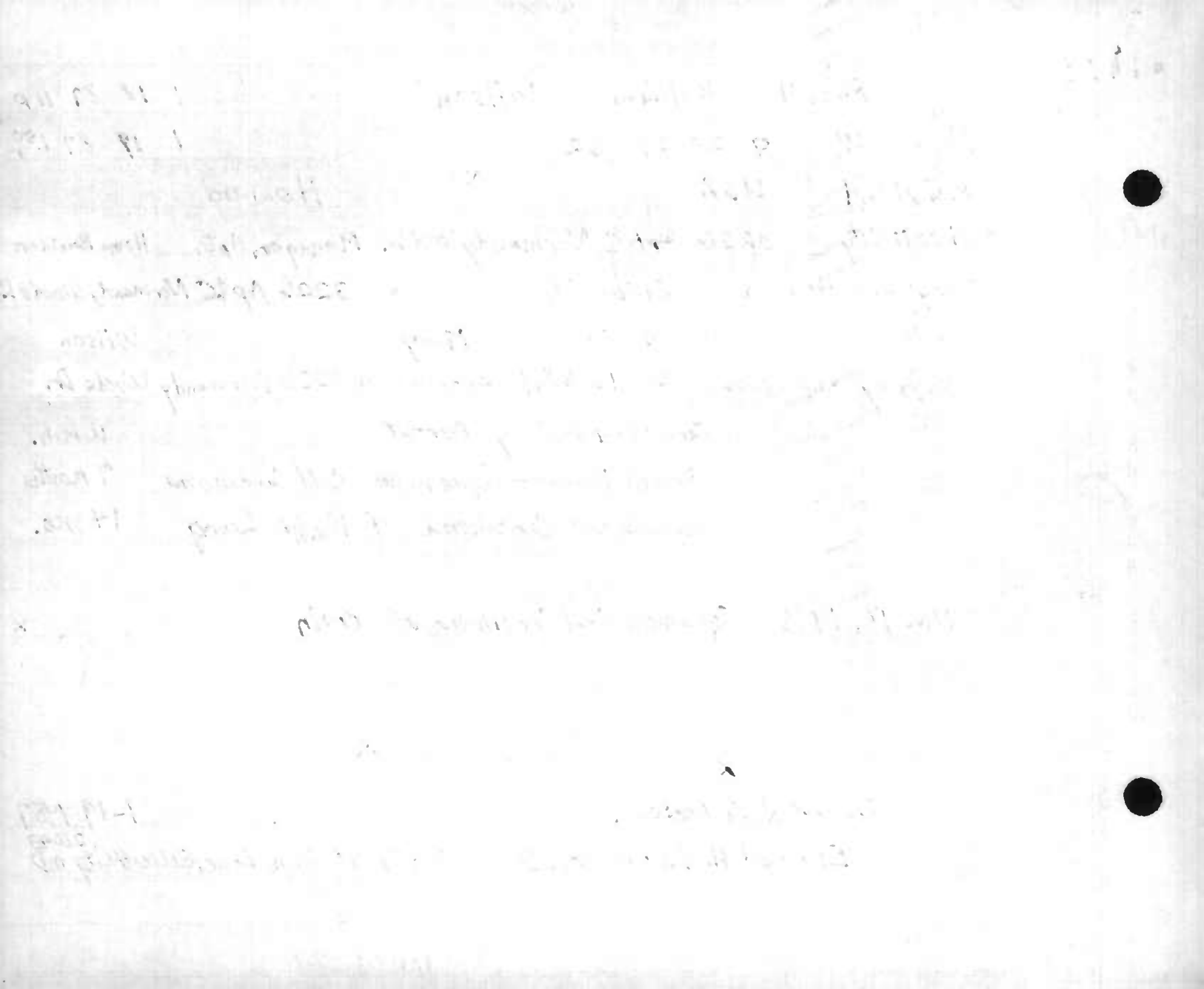
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DHMH-17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02245

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST RONALD MIDDLE William LAST Wilson		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR 1 18 87		2b. HOUR 11 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 25 24	6. AGE (IN YEARS) (LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YR. MONTHS DAYS - -	IF UNDER 24 HRS. HOURS MIN. - -	2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 1 19 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3226 Apt C, Normandy Wood Dr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager, Apts.		12b. KIND OF BUSINESS OR INDUSTRY Home Builders			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3226 Apt C Normandy Woods Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Walsh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Schmidt		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES Yes 2nd Lt. USMC		16b. SOCIAL SECURITY NO. 218-16-3811		17. INFORMANT Mary Wilson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain Tumor - Squamous Cell Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Squamous Carcinoma of Right Lung</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mth. 7 months 14 mo.		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION Nov. 18, 1986		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Squamous Cell Carcinoma of Brain		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Elwood H. La Brosse,		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED 1-19-1987			
EXAMINER'S NAME (TYPE OR PRINT) Elwood H. La Brosse, MD		ADDRESS 3459 St Johns Lane, Ellicott City, MD		21043					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/21/87		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Maryland			
24. FUNERAL DIRECTOR Leland M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228		25a. DATE REC'D. BY REGISTRAR JAN 20 1987		25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place in those transportation papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TERESA G. WILSON									
2a. DATE OF DEATH MONTH DAY YEAR January 12, 1987		2b. HOUR 6:30P M.							
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 17, 1936		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Highland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7027 B Mink Hollow Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse Aid		12b. KIND OF BUSINESS OR INDUSTRY Health	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Highland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7027 B Mink Hollow Road 20777	
14. FATHER'S NAME FIRST MIDDLE LAST Frank S. Vinci				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary L. Trapasso					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 100-28-5472		17. INFORMANT Daniel L. Wilson		ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic ovarian carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Metastasis to lymph nodes, liver. Chronic pulmonary fibrosis. Hypertension, and high cholesterol.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar</i> 19 <i>87</i> , to <i>12 Jan</i> 19 <i>87</i> , that (I) was last saw the deceased alive on <i>23 Dec</i> 19 <i>86</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was <i>did</i> (did not) view the body after death.									
22b. SIGNATURE <i>Donald E. Dillon M.D.</i>				DEGREE M.D.				22c. DATE SIGNED 13 Jan 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dillon M.D.				22e. ADDRESS Rt. 108 2901 Olney-Sandy Spring Road					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/15/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION CITY OR TOWN Dorsey		COUNTY	STATE Maryland
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke 5555 Twin Knolls Road, Columbia, MD. 21045				25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Padilla</i>			

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